BREAKING DOWN BARRIERS TO IMPROVE PATIENT SAFETY EVENT REPORTING

BARRIERS TO REPORTING	TIPS TO OVERCOME
TIME: I am very busy, and it takes too long to report events.	On average it takes **5 minutes** to input any event in the QAC electronic reporting system.
EVENT RECOGNITION: What types of safety events am I expected to report?	Report any unplanned or unintended incident, condition, or circumstance that could have or did result in patient harm (e.g., defective processes, system breakdowns, equipment failures, human errors). **When in doubt, report.**
NO HARM: What is the rationale for reporting the event if no patient harm was involved?	Staff should report no-harm incidents, near misses, and unsafe conditions to **proactively** identify and fix error-prone processes prior to harming patients.
FEAR: I am hesitant to report due to fear of disciplinary actions, potential lawsuits, or guilt of exposing mistakes of others.	Our organization is committed to transparency and a **non-punitive culture** in order to learn from reported safety errors. Don't be afraid to speak up.
FIX & FORGET MENTALITY: Sometimes it is easier for me to fix the error than to report it.	Even if caught and corrected, others have likely experienced the same error. When reported, like-events are analyzed and **lessons learned** are shared across the clinic system.
LACK OF UNDERSTANDING: Why is event reporting important to my clinic organization? Who sees my reports and how is the information used?	Staff have information that, unless reported, remains unknown to the rest of us. Every reported event is reviewed by safety/risk professionals to **drive improvements.**

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